Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

April 4, 2005

1:30 PM

Room 4203

(Diane Van Maren)

Item	**Department**
4270	California Medical Assistance Commission—Selected Issues
4260	Department of Health Services—Selected Medi-Cal Program Issues
4280	Managed Risk Medical Insurance Board—Selected Issues

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Additional issues regarding these departments will also be discussed at future hearings. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

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I. Item 4270—California Medical Assistance Commission (CMAC)

A. Background and Summary of Budget

The California Medical Assistance Commission (CMAC) was established in 1983 to negotiate contracts with specific services under the Medi-Cal Program on behalf of the Department of Health Services. State law and regulations govern the Commission's activities. The Commission is composed of seven voting members appointed to four-year terms.

Major CMAC Commission activities include the following:

- Negotiating contracts under the state's Selective Provider Contracting Program for Medi-Cal fee-for-service hospital inpatient services statewide;
- Negotiating contracts with hospitals for supplemental payments under the (1) Emergency Services and Supplemental Payment Program (SB 1255 funds), (2) Medi-Cal Medical Education Supplemental Payment Program, (3) Construction and Renovation Reimbursement Program (SB 1732), and (4) Small and Rural Supplemental Payment Program; and
- Developing and negotiating per capita, at-risk managed care contracts for health care services to Medi-Cal enrollees with County Organized Health Care Systems and participating Geographic Managed Care Plans.

Summary of Expenditures (dollars in thousands)	2004-05	2005-06	$ Change	% Change
CA Medical Assistance Commission	$2,604	$2,622	$18	0.6%
General Fund	$1,195	$1,207	$12	1.0%
Emergency Services & Supplemental Payments Fund	$111	$108	($3)	(2.7%)
Reimbursements	$1,298	$1,307	$9	0.7%

B. DISCUSSION ITEMS--CMAC

1. CMAC Commission Salaries

Issue: Section 14165.8 of Welfare and Institutions Code provides for the reimbursement of the seven CMAC Commissioners at the annual salary of members of the Legislature, or $99,000 annually. This equates to annual expenditures of $693,000 (General Fund) for their salaries. Generally, the CMAC meets about 23 times per year, or almost twice per month (December being the exception).

Subcommittee Staff Recommendation: Due to ongoing fiscal concerns, it is recommended to reduce the annual salary of the Commission from $99,000 to $50,000, effective as of July 1, 2005, and provide for a cost-of-living adjustment (COLA) as applicable. This recommendation would save $343,000 (General Fund) and requires adoption of trailer bill legislation as shown below.

Amend Section 14165.8 of Welfare & Institutions Code as follows:

The Commission shall be reimbursed at the annual salary of ~~members of the Legislature.~~ $50,000. The Commission shall set the salary of the executive director and other staff consistent with funds appropriated. The annual compensation provided by this section shall be increased in any fiscal year in which a general salary increase is provided for state employees. The amount of the increase provided by this section shall be comparable to, but shall not exceed, the percentage of the general salary increases provided for state employees during that fiscal year.

The recommended $50,000 annual salary is a higher salary level than contained in SB 1083 (Ackerman), as introduced. This legislation proposes for the Commission to be reimbursed at the annual salary of members of the State Personnel Board, or at about $36,251 annually, plus a COLA adjustment if applicable.

The $50,000 annual salary level is recommended in lieu of the $36,251 amount in recognition of the analysis and review functions which the CMAC Commission performs outside of their convened meeting process and the complexities of the hospital financing arena.

Does the Subcommittee want to (1) adopt the proposed trailer bill language, and (2) reduce the CMAC budget by $343,000 General Fund to reflect this salary adjustment?

II. Item 4260--Department of Health Services, Medi-Cal Program *(Selected Issues)*

A. Background Summary of the Medi-Cal Program

Purpose: The federal Medicaid Program (called Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. It is at least three programs in one: (1) a source of traditional health insurance coverage for poor children and some of their parents, (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness, and (3) a wrap-around coverage for low-income Medicare recipients.

Who is Eligible and Summary of Medi-Cal Enrollment: Generally, Medi-Cal eligibles fall into four categories of low-income people as follows: (1) aged, blind or disabled; (2) low-income families with children; (3) children only; and (4) pregnant women.

Men and women who are not elderly and do not have children or a disability *cannot* qualify for Medi-Cal no matter how low-income they are.

Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others—at the state's option.

Medi-Cal provides health insurance coverage to about 18 percent of Californians. Average monthly caseload is anticipated to increase in 2005-06 by about 170,500 enrollees, or about 2.6 percent, for a total of 6.8 million eligibles.

Of the total Medi-Cal eligibles about 38.7 percent or 2.6 million people are categorically-linked to Medi-Cal through enrollment in public cash grant assistance programs (i.e., SSI/SSP or CalWORKs). The majority of the projected Medi-Cal caseload increase is occurring in the working families and children eligibility categories as noted in the Table below.

Medi-Cal Eligibles	2004-05	2005-06	Caseload Change	Percent Change
	(thousands)	(thousands)	(thousands)	2.3%
Families/Children	**4,873**	**4,983**	**111**	**-3.4**
CalWORKS	1,356	1,310	-47	5.3
Working Families	2,853	3,004	151	1.4
Pregnant Women	187	190	3	0.7
Children	477	481	4	3.2%
Aged/Disabled	**1,648**	**1,701**	**53**	**4.1**
Aged	630	655	26	2.7
Disabled	1,18	1,046	28	5.6
Undocumented Persons	**119**	**126**	**7**	
TOTALS	**6,639 people**	**6,810 people**	**171**	**2.6%**

Summary of Budget: The Governor proposes total expenditures of $34.1 billion ($12.9 billion General Fund) which reflects a General Fund increase of $981.7 million, or 8.2 percent above the revised current-year budget.

The General Fund increase primarily reflects (1) increases in caseload and utilization for aged, blind and disabled individuals; (2) increases in federal Medicare premiums for which the state pays; (3) implementation of quality improvement fees and cost-of-living adjustments for nursing homes; (4) elimination of 2004-05 one-time savings; (5) changes in assumptions used for estimating anti-fraud savings; and (6) slower implementation of prior year cost containment activities.

Table: Medi-Cal General Fund Summary

(Dollars in thousands)	**2004-05 Estimated**	**2005-06 Proposed**	**Difference**	**Percent**
Local Assistance				
Benefits	$11,250	$12,193	$940	8.4%
County Admin (eligibility)	621	654	33	5.3%
Fiscal Intermediaries (claims processing)	93	101	8	8.9%
Total Local Assistance	**$11,965**	**$12,948**	**$984**	**8.2%**
DHS Operations	**$112**	**$121**	**$9**	**7.9%**
TOTALS	**$12,077**	**$13,069**	**$993**	**2.6%**

B. DISCUSSION ITEMS-- THE MEDI-CAL PROGRAM

1. Fiscal Appropriations for Funding of Nurse-to-Patient Ratio *(Joint CMAC & DHS*) *(See Hand Outs)*

Issue: The Governor's revised 2004-05 budget and proposed 2005-06 budget both reflect expenditures to *fully* implement the Nurse-to-Patients Ratio Regulations within the Medi-Cal Program as proposed in the enabling DHS regulation package to implement the Nurse-to-Patient Ratios (i.e., October 12, 2002).

Generally, these October 12, 2002 regulations require general acute care hospitals to provide nurse staffing for each hospital unit (e.g., critical care, burn, labor and delivery, medical, surgical, medical/surgical and mixed units) at a specified minimum ratio of nurses-to-patients. These various ratios were required to be implemented as of January 1, 2004, with an enrichment of the ratio to occur as of January 1, 2005.

In a Notice of Emergency Rulemaking issued as of November 4, 2004 (as signed by the DHS Director), the Governor moved to postpone until January 1, 2008 the enrichment of the ratio for medical, surgical, medical/surgical, and mixed units that was set to change from 1:6 to 1:5 on January 1, 2005. Under this timeframe, the Administration had ample time to adjust their proposed budgets (current-year and budget-year) prior to their submittal to the Legislature for consideration (i.e., due as of January 10, 2005). However, no fiscal adjustment was proposed.

Through discussion with Subcommittee staff it became evident that funds appropriated for the Nurse-to-Patients Ratio Regulations had been used by the Administration—both the DHS and the California Medical Assistance Commission (CMAC) for rate adjustments that are not specifically related to the regulations, as directed by the Legislature through the Budget Act of 2004.

In the Budget Act of 2004, $144.4 million (total funds) was approved for 2004-05 (full-year costs) for implementation of the ratios as represented by the October 12, 2002 regulations. This figure was developed by the DHS, and approved by the DOF at the May Revision for submittal to the Legislature. The Legislature adopted the Administration's fiscal proposal as presented because it reflected the amount needed to implement the regulations for this stated fiscal year.

The Administration's fiscal estimate included expenditures for hospitals, as well as for Medi-Cal Managed Care expenditures. In addition, it assumed that the enrichment of the nurse-to-patient for medical, surgical, medical/surgical, and mixed units that was set to change from 1:6 to 1:5 on January 1, 2005 would be implemented.

In addition, as discussed further below, the Administration's fiscal estimate is based on the "Hospital Nurse Staffing and Quality of Care, Hospital Nurse Staffing Survey Analysis" by the University of California, Davis, with adjustments done by the DHS based on the Office of Statewide Health Planning's hospital data system.

At the request of the Subcommittee, the DHS provided fiscal information as to how the Administration expended the current-year (2004-05) funds. The budget year appropriation as contained in the Governor's proposed 2005-06 budget reflects a continuation of that funding.

As shown in the table below, a total of $323.6 million ($161.8 million General Fund) is appropriated in the Governor's proposed budgets across the two-years (i.e., *revised* current-year and the proposed budget year.) for the Nurse-to-Patient Ratios.

Further as noted below, a total of $72.7 million ($36.4 million General Fund) is contained in the Governor's budgets across the two-year period for **implementation of the January 1, 2005 enhanced ratio** (i.e., 1:5 nurse-to-patients). Yet the Governor has proposed to defer the enhanced ratio.

Table—Administration's Calculations for 2004-05 and 2005-06

Medi-Cal Program Budget: **Nurse-to-Patient Ratio Funding for Hospitals & Managed Care Plans**	**Governor's Revised 2004-05 Budget (Total Funds)**	**Governor's 2005-06 Budget (Total Funds)**	**Difference If January 1, 2005 Ratio is Deferred (Total/General Funds)**
I. Fee-for Service (Total)	$80.5 million	$106.8 million	
A. Jan 1, 2004 Ratio (Total)	($71.9 million)	($77.9 million)	
Contract Hospital	$60.4 million	$65.4 million	
Non-Contract Hospital	$11.5 million	$12.5 million	
B. Jan 1, 2005 Ratio (Total)	($8.5 million)	($28.9 million)	$37.4 million ($18.7 million GF)
Contract Hospital	$8.5 million	$28.9 million	
Non-Contract Hospital	0	0	
II. Managed Care (Total)	$67.6 million	$68.8 million	
A. Jan 1, 2004 Ratio (Total)	($45.9 million)	($45.9 million)	
Other retroactive payments	$9.2 million	n/a	
B. Jan 1, 2005 Ratio (Total)	($12.4 million)	($22.9 million)	$35.3 million ($17.7 million GF)
III. TOTALS ($323.6 million)	$148 million	$175.6 million	**$72.7 million ($36.4 million GF)**
A. Total Jan 1, 2004 Ratio/Retro	($127.1 million)	($123.8 million)	n/a
B. Total Jan 1, 2005 Ratio	($20.9 million)	($51.8 million)	$72.7 million ($36.4 million GF)

Joint Letter from the President Pro Tempore of the Senate and the Speaker of the Assembly: In a letter addressed to Secretary Belshe, dated March 7, 2005, President pro Tempore Don Perata and the Speaker of the Assembly Fabian Nunez questioned the expenditure of funds by the Administration for a purpose other than as directed in the Budget Act of 2004. Specifically, the funds were provided to hospitals and managed care plans as a rate increase without a direct linkage to the Nurse-to-Patients regulations, as directed by existing state statute, and as directed by the Budget Act of 2004.

The letter noted that implementation of the ratios has been a legislative priority for the past six years and that they are troubled by the Administration's unilateral action regarding the transfer of the funds. The President pro Tempore and Speaker of the Assembly further note that the transaction should have been communicated to the Legislature before any action was taken.

Background—Original Fiscal Statement in Regulation Package (October 12, 2002) and Updating of Costs: AB 394 (Kuehl), Statutes of 1999, as modified by AB 1760, Statutes of 2000, added Section 1276.4 to the Health and Safety Code. This section requires the DHS to develop minimum, specific numerical licensed nurse-to-patient ratios for specified units of general acute care hospitals. In a regulation package dated October 12, 2002, the DHS made a determination that set forth minimum staffing ratios necessary to protect public health and safety.

The regulations specify the number of patients that may be assigned per licensed nurse in the following hospital units: critical care, burn, labor and delivery, post anesthesia, emergency, surgery, pediatric, intermediate care, specialty care, telemetry, general medical care, subacute care, and transitional inpatient care.

The "Fiscal Impact Statement" in this October 12, 2002 regulation package, which was crafted by the DHS and approved by the DOF, estimated the following expenditures for the Medi-Cal Program for implementation of the ratios:

- $43.3 million ($21.6 million General Fund) for 2003-04;
- $106 million ($53 million General Fund) for 2004-05; and
- $125.4 million ($62.7 million General Fund) for 2005-06.

According to the DHS, the fiscal assumptions they developed were based on the "Hospital Nurse Staffing and Quality of Care Hospital Nurse Staffing Survey Analysis" by the University of California, Davis, as well as data the DHS obtained from the Office of Statewide Health Planning's hospital data reporting system.

The Budget Act of 2003 provided an appropriation of $42.7 million ($21.3 million General Fund) for the Nurse-to-Patients Ratio which corresponds to the amount identified in the "Fiscal Impact Statement" for the first six months of implementation (i.e., January 1, 2004 to June 30, 2004). The fact of the matter is that the "Fiscal Impact Statement" is supposed to reflect an accurate estimate of what the regulations are to cost the state and the Budget Act of 2003 reflected that amount.

The Budget Act of 2004 appropriation reflects a technical updating of the Fiscal Impact Statement, which is expected since overall data and fiscal estimates were updated since the release of the October 2002 regulations.

Background—Legal Status of Governor's Proposed Emergency Regulations (November 2004):

On March 14, 2005, the California Superior Court enjoined enforcement of the Governor's emergency regulations to postpone until January 1, 2008 the enrichment of the ratio for medical, surgical, medical/surgical, and mixed units that was set to change from 1:6 to 1:5 on January 1, 2005. The court order voids the emergency regulation. The Administration is appealing this decision and is requesting the Court of Appeal to stay the Superior Court order.

Due to the court ruling, in a March 17, 2005 letter from Brenda Klutz, Deputy Director, the DHS notified general acute care hospitals that the original Nurse-to-Patients Regulations (October 12, 2002) are in effect.

Background—California Medical Assistance Commission Hospital Contracting: The California Medical Assistance Commission (CMAC), established in 1983, negotiates contracts for specific services—primarily hospital inpatient services—provided under the Medi-Cal Program on behalf of the Department of Health Services. The Commission is composed of seven voting members appointed to four-year terms. In addition, both the Department of Health Services and the Department of Finance serve as ex-officio members on the CMAC Commission. Major Commission activities include the following:

- Negotiating contracts under the state's Selective Provider Contracting Program for Medi-Cal fee-for-service hospital inpatient services statewide;
- Negotiating contracts with hospitals for supplemental payments under the (1) Emergency Services and Supplemental Payment Program (SB 1255 funds), (2) Medi-Cal Medical Education Supplemental Payment Program, (3) Construction and Renovation Reimbursement Program (SB 1732), and (4) Small and Rural Supplemental Payment Program; and
- Developing and negotiating per capita, at-risk managed care contracts for health care services to Medi-Cal enrollees with County Organized Health Care Systems and participating Geographic Managed Care Plans.

In discussions with Subcommittee staff regarding the expenditure of the funds appropriated for the Nurse-to-Patients Ratios in the Budget Act of 2004, the CMAC staff noted the following key aspects:

- All hospital contracts are done on a negotiated basis, and as such, take into account a range of competitive factors unique to each negotiation situation, including the need for funding the Nurse-to-Patient Ratios.
- Most of the rate negotiations affecting the 2004-05 (current-year) took place before the current year budget was passed. Therefore, the 2004-05 affect of the negotiated rate increases includes the impact of rate increases approved in 2003-04 and even earlier when dealing with multi-year rate agreements.
- 90 percent of the estimated 2004-05 (current-year) budget cost of the rate increases was approved prior to November 2004. (When the Governor had the DHS issue emergency regulations to postpone the enriched ratios from January 1, 2005 to January 2008.)
- CMAC continues to negotiate rate increases on an ongoing basis as required by competitive situations as they arise.

Background—Department of Health Services and Managed Care Rate Adjustment:
Generally, the Department of Health Services uses a three-step process for making rate determinations for Medi-Cal Managed Care plans. First, they use a calculation of the cost of providing care for Medi-Cal enrollees which is based on historic data obtained from four County Organized Health Systems (COHS). Second, the DHS adjusts this data based on a number of factors, including audit information, age/sex of the enrollees, enrollee aid code, plan coverage and others. Third, the DHS adjusts the rate based on the state's budget appropriation for the Medi-Cal Program.

According to the DHS, when Managed Care rates were developed for 2004-05, the DHS actuaries who perform the rate calculations adjusted the rates based on the level of funding available in the budget. The rates were developed in the fall for implementation by October 1, 2004 (new rates are usually identified by October 1). The DHS included the funding available for both components of the Nurse-to-Patients ratios. They note that these rates are set and are prospective. The DHS does not allow the rates to be re-opened mid-year unless there is a change that affects the rate by more than one-percent.

Subcommittee Staff Comment: Clearly, the Legislature has appropriated funds through the budget process to fully support the Nurse-to-Patients Ratio. These funds were appropriated in good faith, based on data that was researched and adjusted for the California marketplace and the Medi-Cal Program by the DHS. The Medi-Cal Estimate contains a "policy change"—number 64--which reflects the assumptions used to calculate the amount for the Nurse-to-Patients Ratio (as the policy change is entitled—"Nurse-to-Patient Ratios for Hospitals").

The Medi-Cal Estimate is a complex document which contains dozens and dozens of policy changes which are subject to adjustment when new, updated data becomes available. After all, a budget is an estimate which is adjusted based on many factors. The Medi-Cal Estimate for the Nurse-to-Patient Ratios was indeed adjusted as new data was added to the DHS' assumptions. The dollars were appropriated with the clear intent to fund existing state law for the Medi-Cal Program to fully implementation the Nurse-to-Patient Ratios.

Questions:

1. DHS, Please briefly explain the assumptions used for policy change #64 and the amount of funds provided for 2004-05 and 2005-06.

2. CMAC, Please briefly explain how the contract and non-contract hospital rates are determined. How does the CMAC know if General Fund moneys are available for this purpose?

3. DHS, Are the Nurse-to-Patient Ratios fully funded according to your own Medi-Cal Estimate for 2004-05 and 2005-06?

2. Quality Improvement Fees--$294 million in Revenues Not Captured

Issue: The Administration inadvertently failed to capture $294 million (General Fund) in revenues made available to the state through the implementation of two quality improvement fees as adopted in past budgets. The DOF has acknowledged the error as identified by the Legislative Analyst's Office.

Specifically, the Administration proposed to implement two quality improvement fees in the Medi-Cal Program over the past two fiscal years. Both of these proposals were adopted by the Legislature and included in the Budget Acts (2003 and 2004). One quality improvement fee was implemented for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD facilities) and another was implemented for Medi-Cal Managed Care Plans.

Both of these fees have now been approved by the federal CMS for implementation. (A March 2, 2005 letter approved the Managed Care Plan quality improvement fee which had been pending.)

Generally through this mechanism, certain health care service providers pay a fee to the state. The state places this fee revenue into the state General Fund and then uses a portion of the paid fees to obtain a federal match (at 50 percent). The combined state and federal funds are then used to increase the reimbursement rates paid to the providers paying the fee. The remaining amount of the fee paid by the provider that remains in the state General Fund is reflected as revenue to the state.

The DOF inadvertently did not capture the revenues generated by the fees as being part of the General Fund revenue baseline for 2005-06.

Legislative Analyst's Office Recommendation: In their review of the Governor's proposed General Fund revenues for 2005-06, the LAO recognized that a total of $294 million generated from the above referenced fees was not recognized by the DOF in their General Fund revenue stream.

According to the LAO, the $294 million consists of (1) $58 million from the ICF-DD fees for the current-year, (2) $29 million from the ICF-DD fees for the budget year and (3) $207 million for Managed Care Plans, assuming a July 1, 2005 implementation date.

Subcommittee staff concurs with the recommendation. It should also be noted that the Managed Care Plan quality assurance fee cannot be implemented sooner than the July 1, 2005 date due to the need for some managed care plans to make technical modifications as required by the federal CMS for approval.

Questions:

1. LAO, Please briefly describe the recommendation.
2. DOF, Do you concur with the LAO recommendation and the dollar amount identified?
3. DHS, Please provide an update on the status of including County Organized Health Systems (COHS) in the quality improvement fee program.

3. Quality Improvement Fee—Medi-Cal Managed Care Plans

Issue: The Administration proposes to implement a quality improvement fee on Medi-Cal Managed Care plans as of July 1, 2005 for an overall net savings of $37.7 million (General Fund).

Under the proposal the DHS would assess a quality improvement fee of 6 percent on Medi-Cal Managed Care plans (Two Plan model, Geographic Managed Care, and the AIDS Healthcare Foundation). The amount actually paid by each plan would vary, depending on their gross Medi-Cal revenue.

The quality improvement fee would be deposited into the General Fund and used to (1) obtain increased federal funds to provide a rate adjustment for Medical Managed Care plans, and (2) obtain increased funds to offset $37.7 million in General Fund support in the overall Medi-Cal Program.

Based upon information provided by the DHS, the fiscal arrangement would be as follows:

- 6 percent fee paid by Managed Care plans =$207.2 million to General Fund (11 months)
- State provides plans with rate adjustment =$339 million ($169.5 million GF)
    - Net Increase to Managed Care plans =$131.8 million
    - Net savings to the General Fund =$37.7 million (General Fund)

Implementation of this fee, and rate increase, has been proposed since the Budget Act of 2003. However various implementation issues arose in discussions with the federal Center for Medicare and Medicaid (CMS) as well as with some of the plans. Through trailer bill legislation—SB 1103—enacted as part of the Budget Act of 2004, language was crafted for implementation. However it has taken the federal CMS since last year to finally approve California's request. CMS approval was finally granted as of March 10, 2005.

Medi-Cal Managed Care plans are presently in the process of doing "material modifications" to their lines of business in order to meet certain federal CMS and state requirements. These modifications, which require working with the Department of Managed Care Health (DMHC), are presently in process.

The DHS states that the July 1, 2005 effective date is generally on target. They further note that even if this date slips somewhat, the fee collection and rate adjustment can be done retroactively to July 1, 2005.

It should be noted that the proposal does *not* include the participation of County Organized Health Systems (COHS). According to the DHS, inclusion of the COHS in the Quality Improvement Fee would require a federal law change. Specifically, federal law excludes "health insuring organizations" such as COHS from this financing mechanism. As such, the COHS' are seeking a federal law change.

Background—Federal Law and Quality Improvement Fees: Under the authority of the federal Social Security Act, Title 19, Section 1903(w)(7)(A), any state may impose a "quality improvement fee" on managed care contracts providing services under the Medicaid Program (Medi-Cal in California). According to this federal law and regulations, these state taxes must:

- Be imposed on a permissible class of health care services;
- Be broad-based or apply to all providers within the class;
- Be uniform such that all providers within a class must be taxed at the same rate; and
- Avoid hold harmless arrangements in which collected taxes are returned to the taxpayers either directly or indirectly.

This mechanism can be used to then draw down additional federal funds.

Subcommittee Staff Comment and Recommendation: This is the same proposal as adopted by the Legislature through the Budget Act of 2004 which was not implemented in the current year due to the need for federal CMS approval. Since this approval has now been obtained, Managed Care plans can now proceed with their necessary administrative changes that need to be filed with the DMHC.

The Governor's May Revision will probably contain some minor adjustments to the calculation, but no other aspects are anticipated to change. No issues have been raised regarding the policy. As such, it is recommended to adopt the proposal pending the receipt of the May Revision.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to briefly respond to the following questions:

1. DHS, Please briefly describe the proposal to implement a quality assessment fee for Medi-Cal Managed Care plans.

4. Cost-of-Living Adjustment & Quality Improvement Fees for Skilled Nursing Facilities

Issue: The budget assumes implementation of AB 1629, Statutes of 2004, which **(1)** requires the DHS to provide a cost-of-living-adjustment (COLA) to nursing homes, effective August 1, 2004; **(2)** provides for the establishment of a facility specific rate methodology by August 1, 2005; and **(3)** institutes a Quality Improvement Fee to be effective by August 1, 2004.

In order to proceed with implementation on these three aspects, the DHS needed to do the following:

(1) Obtain federal approval for a State Plan Amendment for the August 1, 2004 COLA (filed with the federal CMS as of September 30, 2004);

(2) Obtain federal approval for a State Plan Amendment for establishing a facility specific rate methodology in lieu of the peer group process presently used for rate setting (filed with the federal CMS as of February 2, 2005); and

(3) Obtain federal approval to waive the federal requirement regarding "uniformity" of the Quality Improvement Fee, as discussed in more detail below (filed with the federal CMS as of March 25, 2005).

The Quality Improvement Fee is 3 percent for the current-year (due to the timing of implementation), and 6 percent for the budget year and thereafter. Revenues from the fee are deposited into the General Fund. It is assumed that General Fund savings of $120 million for 2004-05 and $257 million for 2005-06 will be achieved from the fee.

Costs to the Medi-Cal Program for the cost-of-living-adjustment (COLA) and new rate methodology are expected to be $99 million (General Fund) in 2004-05 and $259.5 million (General Fund) in 2005-06. For the current year these dollars reflect about a 5.7 percent COLA, and for the budget year it is 8 percent (which is the capped level as contained in the enabling legislation.)

Subcommittee Staff Comment: The DHS has filed with the federal CMS all three components necessary to proceed with implementation of AB 1629, Statutes of 2004. However, no federal CMS approvals have been obtained and it is unclear at this time when approvals may be forthcoming.

No policy issues have been raised since the budget reflects implementation of existing statute. However, the enabling state legislation requires federal CMS approval of both State Plan Amendments and the Quality Improvement Fee for the new facility specific rate methodology to go into effect. In addition, the enabling legislation contains a "poison pill" that says if the Quality Improvement Fee ends, then the new facility specific rate methodology ceases.

Therefore, federal CMS approval is paramount for implementation of the enabling legislation and the funding level (need for federal 50 percent match).

Questions:

1. DHS, Please provide a brief description of the fiscal affects of the proposal.
2. DHS, What is the status of each of the submittals to the federal CMS (i.e., the two State Plan Amendments and the rule waiver request)?
3. DHS, Are there any potential fiscal issues that may arise if we do not receive federal CMS approval in a timely manner? Is the COLA for August 1, 2004 at risk?
4. DHS, Is this Quality Improvement Fee at risk due to the President's proposed Medicaid budget which would limit fees?

5. Joint Discussion (MRMIB and DHS) on Prenatal Care Federal Fund Shift

Issue: The Governor's budget for 2004-05 and 2005-06 assumes recognition of recent federal regulations under the State's Children Health Insurance Program (S-CHIP) (Healthy Families in California) that declare an unborn child (from conception) may be considered an eligible child under the program. Under these federal regulations a state may elect to extend eligibility to unborn children using federal S-CHIP funds (a 65 percent federal match rate) for health benefits coverage, including prenatal care and delivery.

California would need to submit an S-CHIP State Plan Amendment (SPA) to the federal CMS for approval in order to obtain the 65 percent federal match. In order to capture the proposed current-year General Fund savings, the SPA must be submitted to the federal CMS by no later than June 30, 2005.

The Governor's proposal would capture state savings—both General Fund and Proposition 99 Funds—through the use of the 65 percent federal match. Specifically the federal match would be used for both the Medi-Cal Prenatal Care Program for Undocumented Women (100 percent General Fund supported now), and the Access for Infants and Mothers (AIM) Program (Proposition 99 Fund supported).

The Governor also proposes new General Fund support for AIM in order to draw down the 65 percent federal S-CHIP match. This increased General Fund amount is shown in the table below. Under Proposition 99 requirements, a four-fifths vote is required to use Proposition 99 Funds to draw a federal match. As such, the Governor's proposal avoids this requirement by using General Fund support in lieu of Proposition 99 Funds.

As illustrated in the table below, the overall fiscal affect of this fund shift is as follows:

- Saves $191 million (General Fund) in Medi-Cal for the two-year period;
- Saves $149.8 million (Proposition 99 Funds) in AIM for the two-year period; and
- Increases by $52.4 million (General Fund) for AIM for the two-year period.

Table: Fund Shifts Resulting from Use of S-CHIP Funds

	2004-05 Fund Shifts			2005-06 Fund Shifts		
Governor's Proposed Funding Shifts	**Prop 99 Funds**	**General Fund**	**Federal Funds**	**Prop 99 Funds**	**General Fund**	**Federal Funds**
Shift Access for Infants & Mothers Program to GF and federal funds.	-$71,354	$24,974	$46,380	-$78,440	$27,454	$50,986
Use S-CHIP federal funds for Prenatal Care to Undocumented Women in Medi-Cal.		-$95,500	$95,500		-$95,500	$95,500
Net Adjustments Overall by Year	-$71,354	-$70,526	$141,880	-78,440	-$68,046	$146,486

The Governor's proposal also uses a portion of the unencumbered Proposition 99 Funds—about $120.5 million across the two years-- to backfill for General Fund support across several different programs, including the State Hospitals that serve individuals with mentally illness, the Expanded Access to Primary Care Clinic Program, Medi-Cal services provided to legal immigrants, as well as other programs. These Proposition 99 Funds-related issues will be discussed at a later Subcommittee hearing as a group.

Overall, the Governor's proposal would save a *net* total of about $259 million (General Fund) across the two fiscal years. This savings level assumes (1) approval by the federal CMS of the S-CHIP State Plan Amendment and therefore receipt of federal funds for AIM and the Medi-Cal Prenatal Care services for Undocumented Women Program, (2) using $120.5 million in unencumbered Proposition 99 Funds available from AIM to backfill for General Fund support in various programs, and (3) providing General Fund support to AIM to draw the new federal match of 65 percent.

Subcommittee Staff Comment and Recommendation: The Governor's proposal clearly has fiscal merit in its use of S-CHIP funds to save General Fund moneys. However, concerns have been raised regarding the need to articulate that receipt of these federal funds for unborn children does not erode or jeopardize existing California law regarding the provision of prenatal care services to women, or existing Supreme Court rulings regarding a woman's right to privacy.

Both the Prenatal Care Program for Undocumented Women and the AIM Program provide comprehensive prenatal care services, including post-partum care, to eligible pregnant women. Though the Administration has not proposed to change existing state statute regarding these comprehensive prenatal care services, the language contained in the federal guidelines is narrower in its interpretation of services. For example, the federal regulations address pregnancy-related services provided to unborn children and does not reference post-partum care.

The Administration contends that since California uses a "bundled" rate of global fee method for our prenatal care programs including post-partum care, in lieu of individual services, the federal CMS will not likely raise concerns. However the federal CMS could raise concerns once they review the S-CHIP State Plan Amendment.

With respect to a woman's right to privacy, concerns have been raised that accepting the S-CHIP funds under the federal regulation's definition of eligible child may place into question Supreme Court rulings regarding a woman's reproductive rights.

The California Health & Human Services Agency (CHHS Agency) is in the process of working with constituency groups to potentially craft language regarding these two concerns. At this time, consensus has not been fully attained.

Therefore, in an effort to facilitate resolution of the issue it is recommended to (1) adopt trailer bill language, as shown below, (2) assume receipt of the federal S-CHIP funds for the Prenatal Care Services to Undocumented Women Program and AIM Program, and (3) require the DHS and MRMIB to provide the Subcommittee with a draft of the proposed State Plan Amendment prior to its submittal to the federal CMS (mid-April). If desired by the Subcommittee, this issue can be revisited at the time of the May Revision and adjustments can be made.

> Proposed placeholder trailer bill language (Add Section xxx to Welfare and Institutions Code):
>
> (a) Through its courts, statutes, and under its Constitution, California protects a woman's right to reproductive privacy. California reaffirms these protections and specifically its Supreme Court decision in *People v. Belous* (1969) 71 Cal.2d 954, 966-68.
>
> (b) The state Department of Health Services and the Managed Risk Medical Insurance Board may accept or use moneys under Title XXI of the federal Social Security Act

(known as the State Children's Health Insurance Program, or S-CHIP), as interpreted in Title 42, Code of Federal Regulations, Section 457.10, to fund services for pregnant women pursuant to Welfare and Institutions Code Section 14007.7 (Medi-Cal) and Insurance Code Sections 12695 et seq (Access for Infants and Mothers (AIM)) only when during the period of coverage the pregnant woman is the beneficiary, the scope of services covered under Medi-Cal and AIM, as defined in statutes, regulations and state plan amendments is no more restrictive than the scope of such services on January 1, 2005, and California's S-CHIP plan and any amendments thereto are consistent with this section.

(c) This section is a declaration of existing law.

6. Administrations Proposal to Implement a Premium *(See Hand Out)*

Issue and Description of the Overall Proposal: The Governor is proposing to require certain Medi-Cal enrollees to pay premiums effective as of January 1, 2007. This proposal requires trailer bill legislation as well as a federal Waiver.

The Administration is seeking an increase of $6.2 million (General Fund) in the budget to begin preparation for collection of the premiums. These proposed expenditures are shown in Table 3, below.

Under the proposal, most Medi-Cal enrollees with incomes above 100 percent of the federal poverty level would pay a monthly premium to maintain their Medi-Cal coverage. The 100 percent of poverty threshold represents **(1)** $1,306 per month for a family of three, **(2)** $812 a month for a senior, or disabled individual, and **(3)** $1,437 a month for a couple receiving SSI/SSP.

Premiums would be required of any family, child, or other individual who have incomes above 100 percent of the poverty level, except for **(1)** individuals with a share-of-cost (they spend down to become eligible for Medi-Cal), **(2)** 1931 (b) families enrolled in CalWORKS, **(3)** infants under one year of age, **(4)** American Indians, and **(5)** Alaskan Natives. Therefore, the primary categories of Medi-Cal enrollees to be impacted by the proposal are:

- Children ages one to six with family incomes above 100 percent, and up to 133 percent, of poverty;
- Seniors and individuals with developmental disabilities with family incomes above 100 percent, and up to up to 133 percent, of poverty; and
- 1931 (b) families with incomes above 100 percent, up to 155 percent, of poverty ($2,024 per month for a family of three), and not enrolled in CalWORKS.

The proposed premium amounts are: (1) $4 per month for children under 21 years; (2) $10 per month for adults; and (3) $27 per month maximum for a family. The table below shows how this would be applied.

Table 1: Administration's Proposed Premium Amounts

Family Size (children, adults, seniors, disabled & pregnant women)	Premium Amount	Annual Payment	Yearly Income>100 percent of poverty
1 child + 1 adult	$4 child x 12 mths $10 adult x 12 mths	$168	$12,504 (1.3%)
2 children + 1 adult	$8 children x 12 mths $10 Adult x 12 mths	$216	$15,684 (1.4%)
1 child + 2 adults	$4 child x 12 mths $10 adult x 12 mths	$288	$15,684 (2%)
Adult (seniors+disabled)	$10 adult x 12 mths	$120	$9,480 (1.3%)
Couple (seniors+disabled)	$20 adult x 12 mths	$240	$16,788 (1.5%)

It should be noted that 1931 (b) families would be treated *differently* with respect to how the Administration makes the premium determination. The Administration proposes to change how the existing earned income deduction will be applied solely for the purpose of determining premiums. In effect, when determining whether premiums are to be paid, a different calculation will be used (i.e., allowing for only a $90 income disregard in lieu of the $240 and ½ disregards). Therefore, the result under this revised calculation is that more families will need to pay premiums because they will be considered above the 100 percent of poverty level.

Further, families enrolled in the 1931 (b) category will have difficulty re-enrolling into Medi-Cal if they are disenrolled due to failure to pay a premium**.** These "recipients" are usually individuals who have left CalWORKS and receive Medi-Cal-only services. The federal Welfare Reform Law of 1996 specifically authorized these individuals to receive Medi-Call services because Congress wanted to transition individuals from welfare to work. One of the barriers to this transition was receipt of health care services. As such, 1931 (b) families can have incomes up to 155 percent of poverty and be eligible for Medi-Cal. However if they loose their existing eligibility, they would be eligible for Medi-Cal-only if their income level was at 100 percent of poverty or below.

Enrollees would be dropped from Medi-Cal if they do not pay premiums for two consecutive months. If re-enrollment is pursued, the individual would be required to pay back premiums owed from the previous six months in which they were enrolled. This can become confusing due to Medi-Cal eligibility retroactivity (which is 90-days) as allowed by federal law.

This proposal would affect children, aged, blind and disabled individuals, and families. A total of about 550,000 people would be required to pay a premium, including about 460,000 families with children, and 90,000 seniors and individuals with disabilities with incomes above the SSI/SSP level.

In the first year alone, the DHS assumes that almost 20 percent of these individuals or about 94,630 individuals will fail to pay and become disenrolled, and thereby add to the increasing ranks of the uninsured living in California. This is shown in Table 2 below.

It should be noted that the DHS assumes that *all dual eligibles* (Medicare and Medi-Cal eligible) will *not drop off* because Medi-Cal pays their Medicare premiums. However in practice this may not occur; therefore, even more individuals could fail to make the premium payment.

Table 2 DHS' Assumptions of Who Drops Off

Eligibility Category (Fee-for-Service & Managed Care) (See Hand Outs for aid code reference)	**Total Medi-Cal Enrollees Needing to Pay**	**Reduction in Enrollees (Drop-Off)**
Aged, Blind & Disabled	90,601	2,817 (3%) (Assumes no duals are dropped)
Children	207,030	41,404 (20%)
Adults (ages 21-64)	252,045	50,409 (20%)
TOTALS	**549,676**	**94,630 uninsured**

The Administration is seeking an increase of $6.2 million (General Fund) in the budget to begin preparation for collection of the premiums. These proposed expenditures are shown in Table 3, below. Counties would conduct a premium calculation to discern if the Medi-Cal eligible person needed to pay a monthly premium. The DHS would contract with a Vendor to conduct the actual collection of the premiums each month.

Table 3 DHS' Identified Administrative Expenditures

Administrative Activity	Proposed Expenditures (General Fund) 2005-06	Proposed Expenditures (General Fund) 2006-07 *(1/1/2007 start)*	Proposed Expenditures (General Fund) 2007-08
County Determination of Premium	$6,200,000 (850,000 cases to review)	$7,200,000 (950,000 cases to review)	$7,200,000
Contract—Collection of Premiums	---	$2,150,000	$4,300,000
DHS State Staff (3.5 positions initially, and more later)	$650,000	$650,000	$650,000
DHS' Total Identified Amount	**$6,850,000**	**$10,000,000**	**$12,150,000**

As noted by the DHS, implementing premium requirements would require a significant new investment in systems and resources. Extensive changes to the Medi-Cal Eligibility Determination System (MEDS) and related systems would be required due to the complexities associated with adding the premium payment collection vendor (contractor) to the eligibility system. In addition by allowing various payment options, along with including numerous exceptions, the premium proposal creates various complexities within MEDS processing.

The DHS notes that, besides hiring 3.5 new staff, the following key administrative activities would be required to implement this proposal:

- Develop and submit a federal 1115 Waiver, and enact state statutory changes;
- Design and implement a new system to handle premium payments and reconciliation, as well as Medi-Cal enrollee notices. Such a system would need to interact with the Medi-Cal Eligibility Determination System (MEDS) to reflect premium related updates. This system could be maintained and operated using either DHS staff or contracted staff;
- If operated through a contract, the DHS would need to do a procurement. It is assumed that a procurement would require from 15 to 21 months to implement from the initial Request for Proposal (RFP) development.
- Develop *several* regulation packages to (1) define terms such as gross and net income, and countable income; (2) specify what sources of expenditures (such as child care costs) will be excluded from family income calculations; (3) specify what sources of income are excluded from the calculation of family income under federal law; (4) specify processes and criteria for appealing financial participation requirements; (5) specify any exceptions for aged and disabled enrollees; and (6) adopt uniform standards for assigning cost sharing requirements for enrollees, including premiums, deductibles and co-pays.

Background-- Administration's Assumptions Regarding Savings: As shown in the table below, the Administration assumes savings from the premium payments from two sources: **(1)** the revenue received from the payment of the monthly premium, and **(2)** from health care costs not provided to individuals because they have dropped off of Medi-Cal due to the non-payment of the premium. These assumptions are open to interpretation since limited research data is available.

It is interesting to note that the Administration assumes no savings for in-patient care services from those individuals who are dropped off of Medi-Cal due to non-payment, and only from two to five percent savings from non-institutional care. This is because the Administration recognizes that individuals will come on and off Medi-Cal as they need services. As such, it decreases the likelihood of "managing" care.

As noted below, the Administration assumes savings of from about $15 million General Fund to about $23 million General Fund on an annual basis.

Table: Administration's Assumed Savings from Premium Payments *(Annualized)*

2007-08 First full year (Annualized)	Aged, Blind & Disabled ($10 for 12 mths)	Children ($4 for 12 mths)	Adults (Ages 21-64) ($10 for 12 mths)	**Total Funds**
***Net* Premium** (After drop-off)	**$10,534,000** (87,783 people)	**$7,951,000** (165,627 children)	**$24,225,000** (201,636 people)	**$42,708,000** (455,046 people)
Dropped from Medi-Cal	2,817 People (3%)	41,404 Children (20%)	50,409 Adults (20%)	94,630 Total
2 % to 5 % Savings for Dropped People	$1,163,000 to $2,908,000	$3,697,000 to $9,244,000	$5,433,000 to $13,584,000	$10,295,000 to $25,735,000
SUBTOTAL	**$11,697,000 to $13,442,000**	**$11,648,000 to $17,195,000**	**$29,658,000 to $37,809**	**$53,003,000 to $68,443,000**
DHS' Assumed Administrative Costs				-$23,044,000
Administration's Net TOTAL (Rounded)				**$29,958,000 to $45,399,000**
Assumed General Fund Savings				**$14,979,000 to $22,700,000**

Subcommittee Staff Comment: The proposal is almost certain to result in a churning of enrollees and increase administrative processing costs. First, under federal law, as well as SB 87 (Escutia), Statutes of 2000, individuals who loose Medi-Cal eligibility under one set of criteria may be eligible for Medi-Cal enrollment under another category. As such Medi-Cal re-determinations must be made. Therefore, all of the Medi-Cal enrollees who are discontinued from Medi-Cal due to non-payment of premiums would conceivably need to be re-determined by the counties.

Medi-Cal re-determination processing can require considerable work on the part of counties**.** Under re-determination processing, a county must first do an "ex parte" review. Under ex parte, the county must check certain public assistance data systems to see if there is appropriate information to make an eligibility determination. If not then additional information is obtained as needed from the individual through telephone contact and if needed, use of a special Medi-Cal form. These administrative costs have *not* been addressed by the Administration's proposal.

Second, as noted by the Administration's own analysis, individuals will drop-off due to the non-payment of premiums and then come back on when they need services (if eligible). This churning of enrollees seems contrary to the Administration's own goal of expanding Medi-Cal Managed Care. Managed Care plans would not appreciate having Medi-Cal enrollees coming in and out of enrollment. This could also result in additional processing costs for the Medi-Cal Health Care Options contractor since they will need to inform enrollees of their health plan choices and enroll them into a plan.

Third, it is unclear how the "Medi-Cal Eligibility Determination System" (MEDS) could maintain its data integrity. Counties maintain MEDS since they perform most Medi-Cal eligibility processing. In the event of Medi-Cal enrollees discontinuing due to non-payment of a premium, it is unclear how the Vendor will notify the county of this action. If the two systems are not in synch with each other, the state could be making Managed Care plan payments for individuals no longer eligible for Medi-Cal, or Medi-Cal enrollees could be inadvertently disenrolled from Medi-Cal.

Fourth, it is unclear how the continuous annual eligibility enrollment of children would be affected if premiums were not paid (such as in the 133 percent of poverty program). The original policy and fiscal concepts behind this annual enrollment was to ensure coverage for children and to reduce administrative costs. It appears that these would not be achieved under the proposal.

Fifth, a clear mechanism for re-enrollment would need to be established, or people's applications could be put on hold indefinitely while they are being asked to pay the premium. What if a parent or child requires medical attention while they are on hold? Should the family spend their money on the medical care, or on paying back their premiums? How will providers of health care know clearly what the status of an individual patient is at the moment of the health care delivery?

Prior Subcommittee Hearings: The Subcommittee has discussed this issue twice previously. In the February 17th Subcommittee hearing as well as in the March 2nd hearing convened jointly with the Senate Health Committee.

Questions:

1. DHS, Are there any additional comments that the Administration would like to convey regarding the Premium proposal that has not been discussed in the prior two hearings?

7. County Performance Standards--Medi-Cal to Healthy Families Bridge *(See Hand Outs)*

Issue: The Administration proposes to expand Medi-Cal performance standards for County Welfare Departments, enacted through the Budget Act of 2003, to now include the Medi-Cal to Healthy Families one-month bridge eligibility processing component. It is assumed that the new standard would be implemented by October 1, 2005.

This proposal contains several components, including: **(1)** trailer bill legislation; **(2)** an increase of $995,000 ($312,000 General Fund) to fund 2.5 new DHS positions and to contract for performance monitoring functions with a vendor; **(3)** an increase of $1.5 million ($500,000 General Fund) in Medi-Cal local assistance for the anticipated *additional* 22,500 children who will receive the Medi-Cal bridge; and **(4)** an increase of $3.1 million ($1.1 million General Fund) in the Managed Risk Medical Insurance Board's budget for the Healthy Families Program for the anticipated 9,907 children who are anticipated to shift from Medi-Cal to the HFP due to the application of the performance standards.

First, the Administration is proposing trailer bill legislation to require County Welfare Departments, who conduct the Medi-Cal to HFP bridge eligibility processing, to meet specified performance criterion regarding the enrollment of these children. This performance criterion is similar to legislation enacted for other aspects of the Medi-Cal Program as part of the Budget Act of 2003.

The trailer bill legislation would require that when a child is determined to change from *no share-of-cost* Medi-Cal to a share-of-cost Medi-Cal, the child shall be placed into the Medi-Cal to HFP bridge benefit program. This is consistent with existing practice as presently done under the bridge.

The trailer bill legislation then would require the counties to meet the following performance criterion for processing the bridge benefit program:

- 90 percent of the families with children placed into the Medi-Cal to HFP bridge shall be sent a notice informing them of the HFP within 5-days from the determination of a share-of-cost.
- 90 percent of the families submitting applications for children placed into the Medi-Cal to HFP bridge shall be sent a notice informing them of the HFP Program within 5-days from the determination of a share-of-cost if the parent has given consent to send the case to the HFP.
- 90 percent of the families with children placed into the Medi-Cal to Healthy Families bridge benefits program who have not consented to sending the application to the Healthy Families Program shall be sent a request, within 5-days from the determination of a share-of-cost, to consent to send the case to the Healthy Families Program.

Further, the trailer bill language provides for a contractor, in addition to the DHS, to obtain performance information from counties and to perform other various monitoring aspects.

Second, the budget proposes the following fiscal adjustments as shown in the table below. Specifically, a total of $6.3 million ($2.3 million General Fund) is being requested across the two programs—Medi-Cal and Healthy Families--, including DHS administrative costs.

The DHS is seeking an increase of $995,000 ($312,000 General Fund) to hire 2.5 positions (two analysts and a half-time Staff Counsel) and to fund a contractor to monitor the counties performance. It should be noted that in the Budget Act of 2003, when overall county performance standards were crafted, the DHS received funds for 9 positions and the contractor concept was rejected by the Legislature. As noted by the LAO, the DHS never filled the positions and instead, eliminated them and used the funding as part of their mandated statewide reductions in state operations for that year.

Table—Total Proposed Increase for Medi-Cal to HFP Bridge Performance

Description of Bridge Components	Governor's Proposed 2005-06 (Total Funds)	Governor's Proposed 2005-06 (General Fund)
I. DHS Requested State Support Total (Assumes a July 1, 2005 start date)	**$995,000**	**$312,000**
• 2.5 new state positions	($252,000)	($126,000)
• Contract for monitoring of counties	($753,000)	($186,000)
II. Medi-Cal Local Assistance Total (To serve 22,500 more children beginning Oct 2005)	**$2,165,600**	**$860,480**
• County Administration Processing	($685,000)	($342,500)
• Medi-Cal Services (one-month bridge)	($1,480,600)	($517,980)
III. Healthy Families Local Assistance Total (To serve 9,907 more children beginning Oct 2005)	**$3,122,454**	**$1,092,859**
• HFP Administrative Vendor	($142,166)	($49,758)
• HFP Services (full on-going enrollment)	($2,980,288)	(1,043,101)
Total DHS State Support	**$995,000**	**$312,000**
Total Local Assistance	**$5,288,054**	**$1,953,339**
Total Proposal for 2005-06	**$6,283,054**	**$2,265,339**

The local assistance funding increase assumes that more children are enrolled in both Medi-Cal and the HFP as a result of the proposal. This is because some children who would otherwise be eligible to receive the bridge benefit program are presently not getting enrolled. As discussed further below, counties contend that enrollment into the bridge is problematic and needs to be revised, including most of the forms and some existing procedures.

According to the DHS, there are *presently* 50,000 children enrolled in the one-month bridge. The fiscal estimate of $2.2 million (total funds) assumes that an additional 22,500 children, or about 45 percent more, will be enrolled in the budget year. Of these additional children, it is

assumed that 9,907, or about 44 percent of the children, will be enrolled into the HFP during the budget year.

Background—The Existing "Bridge": Existing law provides that children who are discontinued from enrollment in Medi-Cal due to increased family income are eligible to apply for enrollment into the Healthy Families Program (HFP). During the application period for the HFP, the child receives one additional month (i.e., bridge) of Medi-Cal eligibility to mitigate any potential break in health care coverage.

Under the existing Medi-Cal to HFP bridge, if a parent has not already consented to their child's information being shared with the HFP, DHS rules require County Welfare Departments to contact the parents of the child who is no longer eligible for no-cost Medi-Cal and request consent from the parent to forward the child's information on to the HFP.

In addition, children moving from the HFP to Medi-Cal are provided a two-month bridge of eligibility while the County Welfare Department completes the final Medi-Cal eligibility determination. This bridge takes effect when the HFP determines at annual eligibility review that the family's income qualifies the child for no-cost Medi-Cal coverage. Therefore, as a families income rises or falls, children can continue to receive health care coverage as they transition to the other program, pending eligibility determination and plan transfer, when applicable. (The Healthy Families Program to Medi-Cal bridge will be discussed along with other Healthy Families Program issues on April 25th.)

Background—The County Performance Standards for Medi-Cal Processing: California currently delegates most administration for Medi-Cal eligibility determinations and redeterminations to the County Welfare Departments and reimburses them with state and federal funds for this work. Federal and state laws require the counties to complete initial eligibility determinations within 45 days of application and to annually redetermine enrollee's eligibility.

Through the Budget Act of 2003, county performance standards for most aspects of eligibility processing in the Medi-Cal Program were adopted. These included standards regarding both enrollment and disenrollment processes, semi-annual reporting, and annual redeterminations. This action has resulted in hundreds of millions in General Fund savings.

On January 1 of each fiscal year, each county is required to report to the DHS on the county's performance of eligibility and redetermination standards, which are subject to verification by the DHS. If a county does not initially meet the performance criterion, then they must submit a corrective action plan to the DHS for approval. Failure to comply with the performance standards can result in a two percent reduction in county administrative funding for Medi-Cal.

Barriers with Existing Bridge Process: In a letter to the Subcommittee, the County Welfare Directors Association identified several "tools" that would enable the counties to better assist families in bridging from Medi-Cal to the HFP. These included the following key aspects:

- *Update all relevant forms and provide instructions to counties:* The application forms as well as the annual redetermination forms which are presently used do not ask parents for consent to share information between programs. As such, the overwhelming majority of parents whose children are not eligible for no cost Medi-Cal must be contacted. In turn, the counties contend that no standard instructions have been provided to counties for how this parental consent is to be obtained and documented (i.e., to show the state "performance").

- *Streamline County Packaging of Materials:* Once parental consent is given to share information across programs, counties must copy the annual redetermination form and "notice of action" form, complete a transmittal form, package the documents together, and mail them to the HFP administrative vendor. The HFP vendor then mails an application to the individual because the HFP vendor will not accept the annual redetermination form as an application for the HFP. As such, the counties are seeking to have the state re-examine these existing procedures to streamline the process.

The DHS and MRMIB have been working with constituency groups to modify various forms but progress has been quite slow.

Legislative Analyst's Office Comments: In her Analysis, the LAO discusses county eligibility processing and monitoring in a broader context than the Medi-Cal to HFP bridge program. As required in trailer bill legislation from the Budget Act of 2003, the DHS is working with counties to develop overall guidelines covering staffing levels, overhead, and expenditure adjustments to control costs while also enabling timely Medi-Cal eligibility processing (i.e., the County Administrative Cost Control Plan). The LAO recommends to have the DHS report back on this plan.

The LAO also recognizes that the DHS was provided 9 positions and funding in the Budget Act of 2003 but used this funding as part of their mandated statewide reductions in state operations for that year. However, the LAO recommends to provide the DHS with four two-year limited-term positions to monitor selected counties' performance overall on an *exploratory* basis.

Subcommittee Staff Comment and Recommendation: Implementation of county performance measures for the Medi-Cal to HFP bridge program makes sense and would be consist with direction provided by the Legislature through the Budget Act of 2003. However, the existing forms should contain a provision for parents to provide consent to share information across programs, particularly the annual redetermination form. Additional administrative costs are being incurred due to the need to mail notices to parents, and worse yet, children are not receiving timely health care coverage or are experiencing gaps in health care coverage.

Therefore with respect to the trailer bill legislation, it is recommended to (1) adopt the Administration's three proposed performance standards for the bridge as proposed, *except* clarify that the performance standards will not commence until 60-days after the revised applicable forms are available, (2) add language to require the state to develop procedures in collaboration with the counties and stakeholder groups for developing implementing instructions for the bridge by no later than September 1, 2005, (3) add language to require the state to issue by no later than September 1, 2005 a revised annual redetermination form that includes a section for parental

consent to be provided, (4) add language to require the state to streamline methods of providing the necessary information for Healthy Families to make an eligibility determination, and (5) delete language that enables a contractor to perform county monitoring activities in lieu of state staff.

With respect to the Administration's request for $995,000 ($312,000 General Fund) in increased DHS state support, it is recommended to (1) approve two Associate Governmental Program Analyst positions for expenditures of $200,000 ($100,000 General Fund), including benefits and operating expenditures, and (2) delete the remaining $795,000(total funds) intended to fund a half-time Staff Counsel III position and vendor contract for monitoring. These two positions can be used to address both the revised forms and streamlining needs identified above, as well as for overall county performance monitoring purposes.

DHS staff should be used to monitor the counties, not contractors. County oversight is a core function of state government and should be performed by the DHS. It should be noted that the DHS operates a Program Review Section which conducts ongoing reviews of county performance as well as ad hoc reviews as needed. Therefore, providing the DHS with two more staff is adequate.

Questions:

1. DHS, Please provide a brief update on the County Administrative Cost Control Plan, and the existing county performance measures.
2. DHS, Please briefly describe the proposed changes to the Medi-Cal Program's county performance process for the bridge benefit program and how more children would be enrolled into Medi-Cal and the HFP under this proposal.
3. DHS, Why is a contractor proposed to do monitoring in lieu of the DHS?
4. DHS, When will revised forms, that contain a request for parental consent for information to be shared, be available?

8. Proposed Changes to the Existing Single Point of Entry Process for Children (See Hand Outs) (Joint DHS and MRMIB Discussion)

Issue: The Administration is proposing to change the existing "Single Point of Entry" process which is used to process the Joint Medi-Cal/Healthy Families applications (designed for children, pregnant women and adult family members).

Under this proposal, the Medi-Cal applications for children received through the Single Point of Entry would now be completely processed by the HFP vendor (presently Maximus) and then sent to the state for final "certification". The state would then send the completed Medi-Cal application to the appropriate county for ongoing case management, including annual redeterminations. The DHS assumes that about 85,000 applications would be processed in this manner.

The table below displays the *net costs* to the state for this proposal in 2005-06 which are $6.8 million ($2.1 million General Fund). This includes increased costs for 19.5 new state positions, as well as vendor contract expenditures and information system changes. It should be noted that the Healthy Families Program inadvertently did not capture the increased costs for the vendor processing in their budget. This is to be corrected in their May Revision budget.

Table: Summary of Expenditures for Single Point of Entry Changes (2005-06)

Governor's Proposed Single Point of Entry (2005-06)	DHS (Total Fund)	DHS (General Fund)	Healthy Families Program (General Fund)
Local Assistance			
Program Savings	($210,000)	($105,000)	
County Administration	($2,182,000)	($1,091,000)	
Vendor Contract Costs	$1,150,000	$0	$1,150,000
Local Assistance	**($1,242,000)**	**($1,196,000)**	**$1,150,000**
Support Cost (19.5 new state positions)	**$6,909,000**	**$2,172,000**	
Additional General Fund Costs of Proposal = $2.1 million	**$5,667,000**	**$976,000**	**$1,150,000**

The Administration contends that savings of $9 million ($7 million General Fund) will be generated annually from this proposal once fully implemented. The savings generated from the proposal would primarily come from children being removed from Medi-Cal. Presently, when the HFP vendor does the initial Medi-Cal screen and the child seems initially eligible for Medi-Cal, the child is placed on "interim status" and is eligible to receive Medi-Cal services pending final determination being conducted by the county of origin. As such, there are some children who receive services who are later found to be ineligible for Medi-Cal and are subsequently disenrolled. The Governor's new proposal would change this practice.

Background—What is the Existing Single Point of Entry Process? Presently, joint applications for children (Medi-Cal and Healthy Families) are submitted to a "Single Point of

Entry" where they are initially processed by the Healthy Families Program (HFP) vendor. The HFP vendor processes the HFP eligibles and then makes an *initial* determination when an applicant appears to be eligible for Medi-Cal

The Medi-Cal applications are then sent by the HFP vendor to the individual's county of residence. The county then makes the final Medi-Cal eligibility determination. As required by both federal and state law, county eligibility systems work through a progression of eligibility determinations in order to identify which category of eligibility is the most appropriate for the child.

For example, the 1931 (b) category of eligibility is the broadest category of eligibility for children. The key aspect of being enrolled in this program is that they receive at least six months of Transitional Medi-Cal if they become ineligible for Medi-Cal at any point during their 12-month eligibility period due to increased family income.

The next broadest category is "regular" Medi-Cal because children are given a larger income disregard than in the "percent" programs if anyone in the family is aged, blind or disabled. In addition, applicants are also allowed to deduct child care costs and eligibility extends to age 21 in this category.

The "percent" programs provide Medi-Cal coverage for (1) infants up to age 1 with family income up to 200 percent of poverty, (2) children aged 1 through 5 with family income up to 133 percent of poverty, and (3) children aged 6 through 18 up to 100 percent of poverty. Unlike the 1931 (b) program and regular Medi-Cal, these percent programs disregard the value of property owned by the family. Children aged 19 and over are not eligible for coverage under these percent programs.

Subcommittee Staff Comments and Recommendation: First, the proposal does not streamline the process. In fact, it adds more administrative bureaucracy by requiring additional shuffling of applications and adding an *initial* 19 new state positions for "certification" purposes. The clients whom the state is trying to serve are not better off. The proposal actually inserts the state into the process when state "certification" is presently not required because counties can certify now.

The proposed change does not even contain enough detail to know how this restructuring of the Single Point of Entry would be implemented. For example, the following questions still remain:

- What information systems processing changes are needed?
- How would coordination between the HFP vendor, state, and counties, be conducted?
- What changes to the Medi-Cal Eligibility Determination System (MEDS) and related systems need to be completed and what is the cost of this?

It is recommended to delete this proposal and save $5.7 million ($2.1 million General Fund).

Questions:

1. DHS, Please explain your proposal, including the cost per case assumptions.
2. DHS, Are all of the anticipated expenditures associated with the proposal reflected in the Governor's proposed budget?

9. Governor Proposes to Capitate Adult Dental in Denti-Cal at $1,000 *(See Hand Outs)*

Issue: The Governor is proposing to restrict the amount of dental services provided to adults to $1,000 in any twelve-month "rolling" period for proposed *net* savings of $48 million ($24.5 million General Fund) in 2005-06. An implementation date of August 1, 2005 is assumed. This proposal requires trailer legislation to enact.

The proposed net savings assumes **(1)** a reduction of $50.2 million ($25.1 million General Fund) in Medi-Cal dental services, **(2)** an increase of $4 million ($1 million General Fund) for a tracking system, and **(3)** an increase of $165,000 ($59,000 General Fund) to fund 1.5 new DHS positions (Information Systems Specialist and a half-time Staff Counsel).

The DHS states that the $1,000 limit would not apply to:

(1) Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in serious impairment to bodily functions (such as a very severe infection, hemorrhage, or trauma related to a dental origin);

(2) Medical and surgical services provided by a dentist which, if provided by a physician, would be considered physician services, including complex maxillofacial surgical procedures and comprehensive oral reconstruction; and

(3) Services that are federally mandated under 42 Code of Federal Regulations, Part 440, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

According to the DHS, about 900,000 adults enrolled in Medi-Cal actually access dental services annually. Of these individuals, about 95,000 Denti-Cal enrollees would be affected by the $1,000 limit. As noted in the table below, over 55 percent of these individuals, or 52,900 people, are aged, blind and/or disabled.

Table: Average Monthly Adult Eligibles Impacted by Proposed Cap

Type of Adult Eligible	Total Adult Eligibles	Eligibles Impacted by Cap
Aged, Blind, Disabled	1,447,500	52,900
All Other Adults (21-64 years)	1,552,000	42,000
Total	2,998,500 (about 900,000 access dental services annually)	**94,900**

The DHS has not been able to provide data regarding what procedures these individuals required and how they would be affected by the limit if one is implemented. For example, it is possible that all of the 95,000 would lose a similar, moderate number of services each year under the limit. However, another scenario could be that a small portion of the 95,000 would lose a significant number of services, while the rest would see a smaller reduction.

The Subcommittee Hand Out package provides four lists of dental procedure information, including; **(1)** dental treatment sequences that would likely exceed a $1,000 cap; **(2)** procedures with an exact fee of $1,000; **(3)** procedures with fees that exceed $1,000; and **(4)** emergency dental procedures.

It should be noted that the Administration will still continue to use their existing "treatment authorization request" (TAR) process for the dental program. As such, TAR's will continue to be reviewed and adjudicated regardless of the 12-month rolling period.

Further, though claims for emergency services do not require a TAR, dental service claims (done by a dentist) must be accompanied by an emergency certification and medical claims (hospital or physician) claims for emergency dental services must have the appropriate diagnosis code to be paid by Medi-Cal.

The Administration assumes expenditures of $4 million ($1 million General Fund) in 2005-06 for the Denti-Cal fiscal intermediary to track each adult enrollee's dental usage. According to the DHS, system modifications are necessary to accumulate the total dollars spent by enrollee, to then edit the incoming claims for exclusions to the cap, and add a capability for providers to call in and "look-up" the balance available for each enrollee.

Participating Denti-Cal providers would need to access this tracking system to check on the usage status of each and every Denti-Cal patient. The DHS maintains that upon implementation of the proposed cap, dental providers would be able to check the enrollee's level of expenditures through a telephone voice response system. Within six-months, the DHS would include a web-based retrieval system.

According to the DHS, the proposed tracking system would operate as follows:

1. Claim is received by Medi-Cal fiscal intermediary (presently Delta Dental).
2. System checks to see if the billed service is excluded from the $1,000 cap.
3. If the service billed is excluded, the claim moves forward to adjudication.
4. If the service is not on the exclusion list, the system checks the prior 12-month paid claim history (back 12 months from the billed date of service).
5. If claim payment history shows that the dental cap will not be exceeded, the claim will move forward to adjudication.
6. If the cap is met, the claim will be denied.

Dental providers would be encouraged to check the tracking system prior to scheduling or providing any dental services to the enrollee. This is because providers will not be able to directly bill Medi-Cal enrollees that are above the $1,000 cap without a written agreement with the enrollee prior to rendering the service.

With respect to state support, the DHS is seeking an increase of $165,000 ($59,000 General Fund) to hire one Associate Information Systems Analyst and a half-time Staff Counsel to implement the proposal.

Finally, it should be noted that the Administration's proposed trailer bill language provides extremely broad authority to the DHS by enabling them to implement this proposal through all county letters, provider bulletins, or similar instructions. Thereafter, the DHS *may* adopt regulations.

Background—Overview of Existing Denti-Cal Program: Individuals enrolled in Medi-Cal are eligible to receive a range of dental health care services. Access to dental services for children under age 21 is required by federal law, whereas adult dental services are considered "optional".

Generally, covered dental benefits for children and adults include: (1) diagnostic and preventive services such as examinations and cleanings, (2) restorative services such as fillings and (3) oral surgery services. Many services such as crowns, dentures and root canals require prior authorization.

State law requires most Medi-Cal enrollees to pay a co-payment for dental care. A $1 co-payment is required for services provided in a dental office and a $5 co-payment is required for non-emergency care provided in an emergency room. As directed by federal law, services cannot be denied to a recipient if a co-payment is not provided

Over 90 percent of Medi-Cal enrollees are eligible for fee-for-service care through the Denti-Cal Program. In addition, about 350,000 individuals receive dental services through managed care arrangements (including Sacramento, San Bernardino, Riverside and Los Angeles).

It is well recognized that the reimbursement rates currently paid under Denti-Cal are very low—generally about 40 to 50 percent of the usual and customary fee charged by dentists in California.

Prior Subcommittee Hearings--Subcommittee Request for Information and Potential Options: In the Subcommittee's March 2nd hearing, numerous issues were raised regarding the Administration's dental capitation proposal, and the Subcommittee chair requested additional information regarding a range of potential options.

First, in response to concerns raised about the potential affect on individuals with developmental disabilities being served through the Regional Center system, the Department of Developmental Services (DDS) was contacted. The DDS noted they had not calculated a fiscal impact for this DHS proposal as part of their January budget estimate for the Regional Centers.

However based on subsequent information provided by the DHS, the DDS estimates that 1,680 Regional Center consumers would be affected at a cost of $1.160 million General Fund for 2005-06 (11 months). If services are not available through Medi-Cal, then the Regional Centers must purchase them using 100 percent General Fund support. The DDS notes that this estimate will be refined at the time of the May Revision.

Second, existing statute provides for one dental cleaning annually. Any subsequent cleanings require a Treatment Authorization Request (TAR) and must be approved by the DHS. Based on data obtained from the DHS, if a TAR was not required for the second cleaning, there would be a 60 percent increase in the number of cleanings (i.e., second cleaning) which would require an increase of $12 million ($6 million General Fund) annually.

Third, there are numerous options that can be crafted for a dental cap. The three key factors are (1) dollar amount of the cap, (2) dental services to be excluded under the cap (not counted towards the cap amount), and (3) the period of time for the cap (one-year or two years, and "rolling" versus calendar year). At the request of the Subcommittee, the DHS has provided fiscal information based on several options as requested. The key options and their estimated fiscal affect are in the Hand Out package. (In reading the options list, the grey shaded area is the area to focus on. This shows the fiscal affect assuming exclusion of emergency services and services provided to individuals residing in a nursing home.)

Subcommittee Staff Comment: The Administration seeks to implement a $1,000 cap in Denti-Cal in an effort to align benefits more closely to the commercial market place. However, Denti-Cal is quite dissimilar to the commercial market place in several ways. It serves more medically needy individuals than the commercial market, reimburses at rates which are generally 40 to 50 percent of the usual and customary fee charged by dentists in California, and has eliminated or restricted services to enrollees due to budgetary constraints over the years.

If a cap is to be implemented, it is suggested to narrow down the potential options for further discussion to the following:

Option Description (***All* assume exclusions for emergency services & long-term care**)	**Impacted Enrollees**	**Estimated Savings (total funds)**
1. Administration's proposal: $1,000 annual cap (rolling) (figures are revised from budget due to emergency & LCT)	93,117	$41,680,000 *(revised)*
2. $1,500 annual cap (calendar year) and no additional exclusions.	37,285	$18,244,000
2. $1,500 annual cap (calendar year) *and* excludes dentures & complex oral surgeries	27,074	$14,020,000
4. $2,000 aggregate cap over two-years and no additional exclusions	34,899	$18,913,850
5. $2,000 aggregate cap over two-years and excludes dentures & complex oral surgeries	34,899	$14,502,000
6. $1,800 aggregate cap over two-years and no additional exclusions	48,159	$25,327,000
7. $1,800 aggregate cap over two-years and excludes dentures & complex oral surgeries	33,388	$19,000,000

If a cap is to be implemented, a sunset date should be placed in the statute to provide for an opportunity to revisit the cap and if needed, adjust rates or other factors to ensure adequate access to dental services. In addition, a "calendar" year (as done in the commercial market) year should be used in lieu of a "rolling" year cap.

Finally, the DHS should not be granted broad authority for implementation. Regulations which require public discourse, versus solely using "all county" letters or provider bulletins, should be used if any aspect of this proposal is adopted by the Legislature.

Questions:

1. DHS, Please provide your technical assistance perspective of the options outlined above.

10. Program of All-Inclusive Care for the Elderly (PACE)

Issue: Constituency groups have raised concerns with the current status of the Program of All-Inclusive Care for the Elderly (PACE) in California. Specifically, nonprofit organizations who have invested resources to develop a PACE program are delayed and have no assurance that their applications will be processed and approved by the DHS in a timely manner. They contend that current PACE providers are unable to expand service areas because of DHS' lack of staff and commitment to the program.

Through the Budget Act of 2001, the Legislature provided $200,000 ($100,000 General Fund) for additional DHS staff to process PACE applications but this was vetoed by the Governor. Through the Budget Act of 2002, the Legislature again provided $200,000 ($100,000 General Fund) for additional DHS staff but the DHS was unable to fill the positions in a timely manner and the funds were swept as part of a reduction to state administration.

According to the National PACE Association, over 65 organizations in California have inquired about developing a PACE. At a minimum, all of the existing PACE providers, as noted below, want to expand their number of sites, and the following organizations are in varying stages of the application process: (1) St Paul's Senior Homes and Services/Community Eldercare of San Diego; (2) LifeSteps Foundation of San Luis Obispo; (3) Santa Teresita Hospital of Durate; (4) Well and Fit ADHC of Diamond Bar; (5) Masonic Homes of Union City, (6) Daylight Adult Day Health Center of San Gabriel, and (7) Downey, Regional Medical Center of Downey.

It should be noted that On Lok, with funding from The California Endowment (TCE), is presently working with federal and state regulators, providers and consumer groups on a project to streamline the regulatory oversight for PACE and other integrated (Medicare and Medicaid) providers. As part of this effort, a task force is exploring what quality indicators are important for seniors and persons with disabilities.

According to the DHS, there are 3.5 positions within the DHS Office of Long-Term Care that are dedicated to processing PACE applications. According to the DHS, it can take up to three DHS staff to bring up one PACE provider, and it can take several years to do so.

Background—What is PACE: PACE providers integrate all Medicaid (Medi-Cal) and Medicare funding and services so that older individuals in need of long-term care can continue living in the community. PACE coordinates the care of each participant enrolled in the program based on individual needs.

PACE provides comprehensive medical and long-term care services, with the program's interdisciplinary team (physicians, nurse practitioners, nurses, social workers, therapists, van drivers and others) fully coordinating these services. PACE programs receive monthly capitated payments from Medicare, Medi-Cal and private individuals depending on the individual's eligibility for public programs.

To be eligible for PACE, an individual must:

- Be 55 years of age or older;
- Be certified by the state to need nursing home care;

- Reside in the service area of the PACE organization; and
- Be able to live in a community setting without jeopardizing his/her health or safety.

PACE providers and the National PACE Association have successfully worked with the federal CMS and State Medicaid agencies to implement PACE nationally. In 1986, Congress authorized a federal demonstration program—PACE—to replicate the successful model of care developed by On Lok in San Francisco. Through the Balanced Budget Act of 1997, Congress set up PACE as a permanent provider type under Medicare and Medicaid (Medi-Cal). In 2002, state legislation was enacted to make PACE a permanent benefit under the Medi-Cal Program.

California presently has four approved PACE providers that have 13 PACE centers in different low-income communities, serving over 1, 700 seniors. The PACE programs include: (1) On Lok in San Francisco, (2) Center for Elders Independence in Oakland, (3) Sutter SeniorCare in Sacramento, and (4) AltaMEd Health Services Corporation in Los Angeles.

Background—PACE is Cost-Effective: PACE receives a capitated Medi-Cal rate, as well as Medicare rate. The Medi-Cal capitated rates provide the state with a 5 percent to 15 percent savings relative to its expenditures for a Medi-Cal nursing home population. PACE programs have full financial risk for services including nursing home placement if participants need this service.

Subcommittee Staff Comment: PACE continues to be a cost-effective model and providers are interested in joining PACE. The Legislature has provided additional staff resources to the DHS in the past, only to have them left unfilled and eliminated. However, continued expansion of the PACE model appears to be warranted. As such, the Subcommittee may want to consider a redirection of two DHS staff for this purpose.

Questions:

1. DHS, Please describe the benefits of the existing PACE model.
2. DHS, Please explain how PACE applications could be processed in a more timely manner.
3. DHS, Is the Administration interested in the continued expansion of the PACE model?

11. Administration's Proposed Acute Long-Term Care Program *(See DHS Hand Out)*

Issue: The Administration proposes to implement a new program—the Acute and Long-Term Care Integration Program through trailer bill legislation (See page 24 of Administration's language). As proposed in the trailer bill legislation, the program would be an expansion of the Medi-Cal Managed Care Program, and *not* simply a pilot project for three county areas (Contra Costa, Orange and San Diego) as originally perceived by many prior to the release of the Administration's language (provided on March 25th).

The language provides the DHS with complete discretion as to how the ALTCI would operate including any federal waivers they choose to seek or any state plan amendment they choose to make, and it provides that they can implement, interpret, or make specific any aspect of the program by means of all county letters, all plan letters, or provider bulletins, or similar instructions. No public discourse through Legislative hearings or regulatory rulemaking would be necessary.

Under the proposal, "Acute and Long Term Care Integration" (ALTCI) health plans would provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities (i.e., Medi-Cal and Medicare eligibles) and would incorporate primary, acute and long-term care services, and home and community-based services and providers in their networks (such as mental health services, social services, personal care services provided under IHSS, nursing facility services, and others). The chart below displays the differences between Medi-Cal Managed Care coverage and the newly proposed ALTCI.

Traditional Managed Care Coverage	ACTCI Coverage
Primary Care	Primary Care
Hospital Care, Emergency Room Services, Surgeries	Hospital Care, Emergency Room Services, Surgeries
Case Management of Medical Services	Case Management of Medical Services
Medi-Cal Scope of Benefits (all offered)	Medi-Cal Scope of Benefits
	Expanded Case Management across medical, social and supportive services with consumer participation as a priority and with interdisciplinary team support. Case Management would have a priority to avoid institutional placements.
	Nursing Facility Services
	Adult Day Health Care
	Personal Care Services (IHSS)
	Mental Health Services
	Home and Community-Based Services (home modifications, personal emergency response systems, nutrition, and others necessary to avoid or delay inpatient nursing facility care.

The integration of Medi-Cal and Medicare funding and services would occur at the health plan level. As such, the participating health plans must also be federally approved as Medicare Plans ("Medicare Advantage plans), and must include Medicare prescription drug coverage.

ALTCI plans would be reimbursed through a capitated payment from the state for Medi-Cal services and a capitated payment from the federal CMS for the Medicare services for eligible members. The plans would assume full risk for a comprehensive array of services including acute hospital care, nursing facility care and home and community based services and supports under this funding mechanism. The DHS states that capitated rates across the entire health and social support continuum creates fiscal incentives for the plans to provide proactive and preventive services to avoid higher costs in institutional settings.

The DHS states that the policy, standards and measures, and safeguards for the ALTCI plans would be developed through a stakeholder process which is going to be convened to discuss the Administration's overall plan to expand managed care. The DHS states that the stakeholder process would be a nine to ten month process with the goal of developing recommendations in early 2006. The DHS contends that identified program changes can then be adopted, implemented, and included in health plan contracts as appropriate. No state statutory changes would be required.

The ALTCI plans would be phased into Contra Costa, San Diego and Orange counties first. These three geographic areas were selected for several reasons. First, these areas have been actively engaged in the state's long-term care integration planning grants process intended to develop integrated local services systems for seniors and the disabled. Second, each represent a different Medi-Cal Managed Care model—Contra Costa has a Two Plan Model, San Diego has a Geographic Managed Care Model, and Orange County operates a County Organized Health System (COHS). Third, each area has an array of home and community-based support services. Fourth, each area has an active stakeholder process.

The Administration wants to implement the model in these counties to facilitate modifications on a smaller scale should they become necessary and to validate the model before it is implemented statewide.

Summary Table of ALTCI Enrollment and Start Dates

ALTCI Areas (Phase I)	DHS Estimated Enrollment (Seniors and adults with disabilities)	DHS Proposed Start Dates
Contra Costa	27,092 adults	January 1, 2007
San Diego	89,417 adults	March 1, 2007
Orange County	74,139 adults	September 1, 2006

Enrollment options for individuals would vary contingent upon eligibility for Medicare and the geographic area. For "Medi-Cal-only" individuals (about 40 percent of seniors and adults with disabilities) living in San Diego or Contra Costa, these individuals will have a choice to either (1) enroll or stay in a "traditional" Medi-Cal Managed Care Plan, (2) enroll in an ALTCI plan, or (3) be "defaulted" into an ALTCI plan if no choice is made.

For the dually eligible living in these two areas (60 percent are dually eligible), the individual can (1) enroll in an ALTCI plan and maintain Medicare coverage separately, (2) enroll in an ALTCI plan and enroll in the same plan for Medicare coverage and Medicare Drug coverage

through a "Prepaid Drug Plan", (3) enroll in a PACE plan if eligible and one is available, or (4) be "defaulted" into an ALTCI plan if no choice is made.

Since Orange County operates CalOPTIMA, all individuals would enroll into its ALTCI plan but could also maintain Medicare coverage separately if desired.

The DHS will use different approaches in selecting the ALTCI plans for the three areas since each area operates a different Medi-Cal Managed Care Model. In Orange County, CalOPTIMA will develop a service delivery system.

Contra Costa as a Two Plan Model will have Contra Costa Health Plan (local initiative) as well as a competitive procurement to select the second ALTCI plan (commercial plan). If the Contra Costa Health Plan does not want to participate as an ALTCI then a second competitive procurement would be done.

San Diego as a Geographic Managed Care Model would use a Request for Application process. The state would release specifications and requirements for ALTCI plans through the RFA process and would review and select participating ALTCI plans based on meeting both state and county requirements. The number or participating plans would be determined by the number of successful applicants.

Core major milestones that the ALTCI plans will need to meet (as presently identified) include the following:

- Apply to the federal CMS to become a Medicare Advantage Plan (subject to federal CMS timelines for Medicare applications);
- Access current home and community-based services provider capacity and utilization in the county. From this data, develop recommendations to the state regarding provide networks.
- Expand and draft ALTCI care management protocols and submit to DHS.
- Establish cultural competency standards including age and disability issues for enrolled populations.
- Participate with the state on Quality Assurance measures for enrolled populations.
- Establish policies to "operationalize" Quality Assurance measures that ALTCI plans must meet to serve the enrolled population.
- Identify assessment tool/protocol and ALTCI service authorization guidelines.
- Assess and build information technology support for comprehensive care management across medical and social services providers/functions.
- Enroll members.

The DHS Office of Long-Term Care presently has 7.5 positions (3.5 positions used for PACE and 4 positions used for the Long-Term Care Integration Projects—see below). Of these positions, two are scheduled to expire as of June 30, 2005.

The DHS is requesting funds for 8 positions (permanent) to perform a number of implementation functions regarding this proposal, and is also seeking an increase of $500,000 to contract for the development and implementation of a Long-Term Care Diversion Assessment Protocol.

It is the intent of the state to have the ALTCI plans work with a contractor on the development and implementation of a uniform Long-Term Care Diversion and Assessment Protocol for seniors and adults with disabilities. This protocol would be used to determine functional needs and preferences and to ensure that seniors and adults with disabilities receive care that supports maximum community integration and self-direction.

The DHS notes that the development of this protocol will involve stakeholders, including consumers, advocates and representatives from home and community-based programs, and is consistent with the United States Supreme Court's Olmstead decision for community integration.

Background—Long Term Care Integration Projects: The Legislature authorized planning grants commencing in 1998 as a result of state and local interest in creating a more efficient delivery system for seniors. The first grants were allocated by the DHS in 1999. A total of $2.6 million (General Fund) has been awarded to 16 counties between 1999 and 2004.

Both San Diego and Contra Costa counties have sustained ongoing planning efforts and were the first entities to receive "implementation" grant awards (total of $897,500) in 2004-05 to precede with various integration activities. These funds are continuing into 2005-06.

Subcommittee Staff Comment: The Administration's proposal to craft a new ALTCI Program for seniors and adults with disabilities has merit. Consumers with chronic care needs and long term care needs often must seek services and supports from several distinct health care programs and home and community-based service entities, each with its own separate assessment process and care plan. Discussions regarding the integration of programs that serve this community has been ongoing for several years.

However, such a comprehensive effort should not be enacted through the budget process particularly when significantly more work needs to be completed prior to any implementation, even one that is "phased-in". Policy legislation which provides a framework for the program and enables the three areas to proceed as a pilot could be crafted by the Administration in lieu of trailer bill legislation.

The Administration is seeking broad authority in their language to proceed with federal waivers and state plan amendments prior to working with stakeholder groups to more definitively frame the proposed ALTCI Program. Many issues abound as to even what kind of waivers the Administration will be seeking or how cost-effectiveness would be calculated. Considerable discussion with the federal CMS still needs to occur regarding issues pertaining to both the Medicaid (Medi-Cal) and Medicare programs (100 percent federally funded), as well as many of California's social services programs and mental health programs.

No fiscal analysis of the proposal has been provided and only last week was a paper even describing the proposal provided to the Legislature. In addition, the LAO has submitted numerous questions to the Administration regarding the proposal and responses are still pending.

If desired, the Subcommittee could (1) approve the $500,000 for the Long-Term Care Diversion Assessment Protocol to be developed, and (2) provide two to three staff to continue work with the three counties and to commence with stakeholder discussions. However is it recommended to reject the proposed trailer bill legislation. There is ample time for a new program such as this to proceed through the Policy Committee process.

Questions:

1. DHS, Please describe the key aspects of the proposed ALTCI Program.
2. DHS, Please describe what federal waivers would be needed for implementation and what specifically would be waived?
3. DHS, Please describe the proposed trailer bill legislation (reference Hand Out if needed).
4. DHS, Please describe your proposed schedule for implementation.

12. Administration's Medi-Cal Managed Care Proposal—*Informational Only*

Issue: The Subcommittee has convened two public hearings in which the Administration's proposal to expand Medi-Cal Managed Care has been discussed. Through these discussions several concerns have been raised, including issues related to: (1) access to health care, particularly for seniors and persons with disabilities, but also for certain rural populations in some counties proposed for expansion of the program;(2) the lack of quality indicators specific to the senior and persons with disabilities population, and (3) setting Medi-Cal Managed Care rates.

A. Access to Care and Care Coordination: According to data recently analyzed by the Lewin Group through a project under the management of the California Healthcare Foundation (CHF), Medi-Cal enrollees who are in fee-for-service and are categorically aged, blind or disabled are much more likely to have chronic conditions than all other Medi-Cal aid codes. For example, they note the following:

- At least 45 percent have Pulmonary disease (compared to 20 % of other enrollees)
- 40 percent have musculo-skeletal concerns (compared to less than 10% of others)
- Almost 30 percent have significant mental health concerns (others less than 5 percent)
- 25 percent have hypertension (others less than 5 percent)
- 20 percent have cardiovascular disease (others less than 8 percent)

Since these individuals are proposed to be enrolled on a mandatory basis under the Managed Care expansion, how is access to care for specialty physicians and services going to be achieved and how is care coordination to be managed?

"Access to care" encompasses many activities and features that guarantee, enhance, or promote access to care. These may include network access standards (e.g., provider to member ratios, time and distance standards to health care services), requirements for physical accessibility (e.g., ADA compliance) and translation/interpreter services, and requirements for access to particular provider types, second opinions, and other services.

The federal Balanced Budget Act of 1997 requires states to apply certain federal regulations that govern state Medicaid (Medi-Cal) contracts. As noted by the CHF analysis, in many cases states have developed additional or specific requirements to address local concerns or market conditions.

Care coordination may include definitions and requirements for case management, disease management and care coordination. Coordination of care may include coordination with other managed care organizations, other state programs, non-capitated services and/or family members. Care coordination may also include requirements for developing individual care plans, authorization of services and the credentials of care coordination staff.

Again, the federal Balanced Budget Act of 1997 requires states to apply certain federal regulations that govern state Medicaid (Medi-Cal) contracts. As noted by the CHF analysis, in many cases states have developed additional or specific requirements to address local concerns or market conditions.

Questions:

1. DHS, Could you please describe whether the state presently has any additional or state-specific requirements to address local concerns or market conditions now for these areas and if so, what are they?
2. DHS, How may the existing practice change with the proposed expansion? Please be specific.

B. Quality Indicators Specific To Seniors and Persons with Disabilities Population: As noted by the CHF materials, state Medicaid programs often rely on national performance measures and too few of these measures focus on people with disabilities. They note that this may be attributed to limited information about evidence-based practices, prevalence relative to other conditions, and commercial purchaser priorities (which tend to drive national measurement sets). The development of performance measures for this population is needed and is necessary in order to ensure quality. Considerable work will need to be done in this area. The table below displays what California presently uses in the Medi-Cal Managed Care Program.

Medi-Cal Plan	**Reporting/Monitoring**	**Frequency**
County Organized Health System	• Health Plan Employer Data (HEDIS)—7 measures • Standards & Performance Requirements for linguistic services	Annually
Local Initiative	• External Accountability Set (by county) • Under/Over-Utilization monitoring • Consumer Satisfaction Survey • Group Assessment for Cultural Linguistic Needs	Annually Annually DHS decides 5 years
Commercial	• External Accountability Set (by county) • Under/Over-Utilization monitoring • Consumer Satisfaction Survey • Group Assessment for Cultural Linguistic Needs	Annually Annually Annually 5 years

Questions:

1. DHS, Please briefly discuss the existing quality indicators. What does the DHS do with the information?
2. DHS, What additional quality indicators are being contemplated? How will stakeholders be involved in this process?

C. Medi-Cal Managed Care Rate Structure: Questions regarding the existing Medi-Cal Managed Care rate structure have been evolving for several years. As noted by the LAO in past Analyses, the existing methodology is outdated.

Though the DHS did change its methodology in 2003 in order to meet federal law requirements to be actuarially based, amongst other things, the DHS does not use encounter data to make rate determinations.

The "base cost" is the part of the rate that relates to experience from the past. Generally, to calculate the base cost, an attempt is made to find a group of individuals that will be similar to the group for which the rates are being set. Claims tapes for four COHS's is used for determining the Two Plan Model rates. Various adjustment factors are applied to the base costs, such as for age/sex population mix, enrollee's duration of Medi-Cal enrollment, trend factors for hospital inpatient and outpatient services, trend factors for pharmacy, and other factors. In addition, changes made through the state budget process are also to be factored in as part of the process.

Currently there are contract provisions that provide for an administrative remedy and an appeals process when disputes are raised by the plans regarding contract issues. These provisions are included in the Two Plan Model, Geographic Managed Care and the COHS contracts. Specifically, there is (1) an initial "notice of dispute" process, (2) an administrative appeals process, and (3) a Writ of Mandate process which is filed with the Superior Court to protest the Administrative Appeal decision. Within the last two-years, 15 plans have filed some form of Administrative Appeal regarding rates. Four cases have been taken to Superior Court.

The DHS notes that they have recently awarded a contract to Mercer which begins May 1, 2005. Expenditures in the current year for this contract are expected to be $300,000 (total funds) and $1 million for 2005-06.

Questions:

1. DHS, Please provide an overview of the existing rate determination process for Medi-Cal Managed Care.
2. DHS, Please provide an overview of the work products to be produced by Mercer.
3. DHS, How may this new information be used to develop a revised rate methodology?

Background for Reference—Summary of the Administration's Proposed Managed Care Expansion: The Administration's Medi-Cal Managed Care expansion would be achieved through a phased-in process over a twelve to eighteen month period commencing in January 2007. The Administration's proposal would require (1) state statutory changes, (2) approval of a federal Waiver, and (3) adoption of state regulations.

It is anticipated that 816,000 additional Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion. These 816,000 new enrollees, of whom 554,000 would be aged, blind or disabled, would represent an increase of over 25 percent

The proposed expansion assumes the following key components:

1. Expansion to 13 New Counties: The Administration would expand Medi-Cal Managed Care to 13 additional counties, including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

The Administration assumes the following Managed Care model configurations for these new counties:

- Include El Dorado and Placer counties in the existing Sacramento GMC;
- Include Imperial County in the existing San Diego GMC;
- Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
- Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

2. Aged, Blind and Disabled Individuals (Mandatory Enrollment): The DHS has identified 36 Medi-Cal aid codes which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. It is assumed that about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09. The 554,000 new enrollees represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).

The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

13. Disease Management Pilots: Status Update and Funding Level Discussion

Issue: The budget proposes expenditures of $4 million ($2 million General Fund) in Medi-Cal local assistance to contract with at least two disease management organizations in 2005-06. This funding level assumes a July 1, 2005 implementation date.

Through the Budget Act of 2003 and accompanying trailer legislation, the Legislature authorized the DHS to apply for a federal Waiver to test the efficacy of providing a Disease Management benefit to Medi-Cal enrollees. The DHS received three state positions for this purpose.

According to the DHS, implementation of the Disease Management Pilots is behind schedule. Based on the most recent schedule, at the *earliest*, the awards for the contracts will not be made until mid-December, 2005. Specifically, the following activities need to be completed:

Activity	Estimated Completion
• Submit State Plan Amendment (SPA)	May 31, 2005
• Federal CMS approves SPA	August 1, 2005
• Submit Request for Application (RFP) to Medi-Cal Procurement	August 1, 2005
• RFP released to bidders	November 1, 2005
• Bid/Evaluation process completed	December 15, 2005
• Contract awarded	December 15, 2005

This schedule is contingent upon (1) a timely federal CMS approval of the SPA, (2) a timely release of the RFP to bidders, and (3) no protests from bidders.

Background—Disease Management and Its Use: Existing state statute defines "disease management programs and services" as services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based, or consensus-based practice guidelines and patient self-management strategies.

Existing statute defines a "disease management organization" as an entity that provides disease management programs and services, which contracts with any of the following: a health care service plan; a contractor of a health care service plan; an employer; a publicly financed health care program, or a government agency.

Disease management can improve the quality of life of patients by catching health-related problems early, enabling patients to subsequently avoid high cost medical treatments and procedures—especially those associated with hospitalizations. Evidence of the efficacy of these programs has been shown for a variety of chronic conditions including diabetes, coronary artery disease, chronic obstructive pulmonary disease, asthma, renal disease and other chronic illnesses.

The expansion of disease management programs is a nationwide trend. At least seven or so states have implemented Disease Management pilots for Medicaid (Medi-Cal) enrollees through a federal Waiver, and 30 states have implemented various types of Disease Management Programs since at least 1995.

Legislative Analyst's Office Comment: The LAO notes that Disease Management Programs, particularly for asthma, diabetes, renal function failures, chronic obstructive pulmonary disease and depression, can be effective. For example they note that a one percent reduction in costs for these five chronic conditions could result in annual savings of $15 million ($7 million General Fund)

Subcommittee Staff Comment and Recommendation: Implementation of Disease Management Projects within Medi-Cal is over due and the schedule has slipped to be a January 1, 2006 implementation date, at the earliest. As such from a strictly fiscal perspective, it is recommended to reduce the Disease Management Projects by $2 million ($1 million General Fund) to reflect a six month implementation amount for 2005-06.

Questions:

1. DHS, Please describe the projects and the updated schedule.

14. Medi-Cal Assistance Claiming—Request for DHS Staff

Issue: The DHS requests an increase of $938,000 ($469,000 reimbursements from Local Government Agencies and $469,000 in federal funds) to support ten new positions due to increased workload associated with Medi-Cal Administrative Activities (MAA) and the Targeted Case Management Program (TCM). Specifically, eight of the positions would be for MAA and two would be for TCM. No General Fund support is necessary.

The DHS states that positions are required to manage the continuous growth in MAA claiming and need for TCM oversight. More local entities are interested in MAA claiming because these federal matching funds are not capped and are an under utilized source of revenue. The DHS estimates that MAA claiming will be $430 million (federal funds) for the current-year. The TCM positions would be used in the Audits and Investigations unit to conduct financial and compliance audits of local entities accessing these funds and periodic site reviews.

Background—MAA and TCM Programs: The MAA and TCM programs enable county departments of public health and local education consortia to receive federal reimbursement from Medi-Cal for the cost of providing services for certain activities. Public health departments and local education consortia contract with the DHS to manage their MAA and TCM programs (i.e., process invoices, contracts and claims for federal matching funds). These contracts finance, among other things, (1) local outreach for Medi-Cal, (2) facilitation of Medi-Cal application/enrollment, (3) case management to specific target populations, and (4) claims administration.

Subcommittee Staff Comment and Recommendation: No issues have been raised. The requested DHS positions require no General Fund investment and the workload is justified. Therefore it is recommended to approve as budgeted.

Questions:

1. DHS, Please explain your need for the eight positions.

LAST PAGE OF AGENDA.